Consumer Responses to A+ Questionnaire

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Beth,

The information below is the summary of common themes from the input of eight consumers and six family members. As requested by the format, where there were areas of disagreement, the unresolved areas are identified.

I selected out only the portions of the questionnaire that seemed relevant to consumer/family perspectives. Each question answered is identified by the page number, and question number under the identified heading.

Anne

Page 2, question 1.2: thoughts on the kind of changes that can happen to the program and services because of moving to a new facility:

The overwhelming theme was about the opportunity for more space that is a more healing environment and offers more opportunities for increased programs, but most importantly, for access to physical activities, open outdoor space, and opportunities to interact in the community/socially or have the community interact with patients. Normalcy (even an idea for "apartment style" units clustered around common areas) was also stressed. Among the comments that summarized typical thoughts:

"Integrate presence of the community into the hospital so that transition to the community starts in the hospital."

"More appropriate (safe) spaces so that higher-acuity patients can participate."

"Exercise and fresh air are important components of any treatment plan; a space for walking outdoors."

And finally — the opportunity to not think in terms of "replacing the current hospital" but rather to think in terms of evolving into another form that utilizes the best of the staff and the concepts of care that exist at VSH."

Page 7, Program Policy Considerations, question 4; defining what spaces should be open to patients or secured when not in use:

a. kitchen. The consensus was that a kitchen that was the functional service for the hospital would need to be off-limits for patient safety, but it would be a benefit to have supervised access to some kitchen facilities or complete access to a safe location to be able to get food items at times outside of scheduled meal services. (Access to "comfort food" is important.)

b. dining area. There was broad consensus that this should be designed as an area that would remain open, so that it could have multiple purpose use such as for projects, activities, visiting, etc.

c. bedrooms. The majority felt bedrooms needed to be designed to allow access at all times ("sometimes patients need to get away from others"), but one person cautioned that while having options was important, there were times when being able to "retreat to one's bedroom" was not a healthy choice, and that it might be better to have designated amounts of time patients were expected to be in common space, but with individual choice of when those times were.

d. recreation space. Except for necessary restrictions based on adequacy of staff for supervision, there was strong sentiment that there should be as much open access to recreation space as possible, as well as a variety of recreation activities that were physically active, including outdoor sports.

e. particular kinds of recreation space. Some type of recreational space should be accessible at all times, perhaps smaller spaces such as a game area or area for low impact exercise; "for people who have insomnia or need a place to work off stress."

f. community living training space. (Lack of consistency understanding this use.)

g. vocational training. Scheduled use only. One person believed this should only be occurring outside of a hospital setting.

Page 12, question 8.2, Critical Adjacency Relationships:

There were few strong feelings on these, and no real consensus. Visiting areas were suggested as preferred to be close to patient areas, but with access to privacy. There was disagreement about whether visiting should in a completely separate area (for confidentiality) or specifically include patient common areas ("interacting with other patients was a good experience for us and for them.")

There was a mix on whether all bedrooms should have private bathrooms ("for dignity and privacy"), or some should, but areas for more acute patients should have common bathrooms in adjacent halls for better supervision/safety. Only one person identified a specific preference for common bathrooms, "so that patients are required to accommodate to sharing a space with others."

Page 15: Therapy/Activity

1. How much space should there be, and what kinds of space, for recreation?

Reiteration of the importance for large outdoor spaces, sports and physical activity, as well as many choices and options possible for patients for types of indoor recreation, such as a library, other quiet space, music room, arts and crafts area. "Recreation involves building friendships, interpersonal relationships. That deserves space."

2. How much space should there be, and what kinds of space, for socializing?

"Homelike" living room areas; smaller spaces that are quieter (away from recreational/game room/TV type areas), as well as at least one space away from sleeping areas for evening socializing to not disturb those sleeping. A canteen area was suggested by several. "As much as possible all areas where

one would socialize in a home and community should be reflected in the hospital."

3. What kinds of vocational activities, and where on the unit should they be?

Emphasis was on one-to-one counseling and access to information, during inpatient stays. Access to computers/ computer training was a theme that came up several times. One person had a differing view, seeing work as part of healing activities and suggesting craft work, spinning and weaving to then sell products to the public.

Pages 15-16, Clinical Ancillaries.

How should patients come into the hospital? How important is it to use the same admissions area as other hospital patients, or to have a separate one?

How important is it to use the same emergency room (with its existing separate psychiatric exam rooms) or to have a separate one?

[These two questions were merged due to basically overlapping discussion.]

The closest to agreement/compromise was that both options should be available: that patients could access the same admissions and ER as all patients, or access a special/separate entrance for special situations and needs. Many people felt very strongly that safety and patient dignity meant that specialized intervention should be available, with less stress for patients. Some felt equally strongly that self-esteem/dignity was best met by being within part of the usual admission process (not to "add to stigma by admitting MH patients through the back door,") that the emergency room "should be properly equipped to handle any emergency properly" and that this was also important to proper diagnosis, since some medical problems can initially present as psychiatric symptoms. There was broad agreement that if there was police involvement, restraint, or a person in acute crisis, there was a need ensure privacy from other patients/public.

Where should after-admission exams be done: in a centralized area that has an exam room, or on each unit?

Whatever allows for the most stress-free, calm environment.

Should meals be in a larger common area, in smaller unit dining rooms, or other?

Consensus for smaller areas on the unit (less overwhelming), plus allow for the option of meals in room when appropriate.

Page 17, Administrative Services

Q. 6: Should there be an office for Legal Aid and other advocates (e.g., P&A) to work from when there at the hospital? Should it be on the unit?

Universal support for on-site office, but split on whether such an office should be located on the unit itself ("a central space that provides privacy but that is visible; the more visible the staff is, the easier for the patients to seek them out") versus nearby within the hospital but not on the unit ("some people would feel more a sense of privacy and freedom to speak off the unit.")

Should there be a visiting judge's court on or near the unit (like at VSH?)

Yes (near unit, not on it) — maybe space could double for other meetings?

Page 20: Facilities Management

Q. 5: Should there be security personnel for the psychiatric facility specifically, or part of the general hospital security?

There was consensus that any security personnel needed to have training and expertise in psychiatric care and de-escalation. There was a split between those who felt this meant there was a need for separate personnel, and those who felt that all security personnel should have that level of training.

Page 20: Family Support and Visitation

Q. 1: What kind of space should there be for visitors? Where on the unit should it be located (and what adjacencies)?

There was no resolution of the tension between confidentiality and of the benefits of casual socializing in areas open to patients and visitors alike. Comments included that: bedrooms should be roomy and pleasant enough for optional private visiting; lounge and central areas should be used ("open

areas for patients and visitors to mingle is important"); separate room near the entrance but not visible to the patient area; near enough to staff for oversight as needed for safety.